Commonwealth of Virginia **Department of Social Services (DSS)** **ABD MEDICAID RENEWAL** **Name:** **Address:**	**CASE NAME:** **CASE NUMBER:** **DATE MAILED:** **WORKER'S NAME:** **TELEPHONE NUMBER:** **LOCAL AGENCY ADDRESS**

Please answer ALL questions and return the form by _____. If you have any questions, please call the worker named above.

1. **Has your address changed? Which has changed? ☐ Mailing address ☐ Home address**

   Give us your correct address:_____

2. **Please give us your current telephone number:** _____

3. **Does your spouse or your child(ren) under age 21 live with you? ☐ No ☐ Yes If Yes, tell us their names and their relationship to you:** _____

4. **List all the money received by you or your spouse during the past month. List Social Security benefits, VA benefits, wages, retirement benefits, disability benefits, unemployment, etc. Attach proof of the amount received. Proof of SSA, SSI, or unemployment is not required.**

Who received money?	Source	Amount
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____

5. **If you or your spouse who lives with you are working, do either of you have expenses related to work? If yes, list what kind of expenses you have and attach proof.** _____

   _____

6. **List changes in your health insurance, including company name, policy number, coverage, what the change was and the date of change:**_____

   _____

7. **Do you or your spouse have any of the following resources (check all below that apply and attach proof):**

   - ❑ **Checking/Savings Accounts**
   - ❑ **Certificate of Deposit (CD)**
   - ❑ **Annuity or Trust Fund**
   - ❑ **Stocks, Bonds**
   - ❑ **Life Insurance**
   - ❑ **Burial Funds**
   - ❑ **Vehicles (car, truck, RV, boat)**
   - ❑ **Real Estate, Life Rights/Estate**
   - ❑ **Pension Plan, 401k, IRA, other Retirement Fund**

Resource	Owner	Where it is located	Value
_____	_____	_____	$_____
_____	_____	_____	$_____
_____	_____	_____	$_____

8. **Have you sold or given away any resources? ☐ No ☐ Yes If Yes, attach a statement explaining what you sold/gave away, the date you did this, and what you received in return.**

9. I have given true and correct information on this form to the best of my knowledge and belief. I understand that I must report ownership of all annuities my spouse or I have. I also understand that for Medicaid to pay long-term care costs, my spouse and I may be required to name the Commonwealth of Virginia as the beneficiary on any annuities we have. I understand that if I give false information, withhold information, or fail to report a change, I may be breaking the law and could be prosecuted. I authorize DSS and the Department of Medical Assistance Services (DMAS) to obtain from any source, any information needed to determine my eligibility for medical assistance.

_____/_____ _____

Signature of Recipient/Authorized Representative **Date** **Relationship to Recipient**

Telephone Number _____

Voter Registration – Check one of the following:

If you are not registered to vote where you live now, would like to register to vote today?

☐ Yes, I would like to register to vote. (If you would like help filling out the voter registration application form, we will help you. The decision to accept help is yours. You also have the right to fill out your voter registration application form in private.)

☐ I do not want to apply to register to vote today.

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

Applying to register or declining to register to vote will not affect the amount assistance or services that you will be provided by this agency. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with: Secretary of the Virginia State Board of Elections, Ninth Street Office Building, 200 North Ninth Street, Richmond, VA 23219-3497, (804) 786-6551.

DO NOT FILL OUT THIS PART********AGENCY USE ONLY **********

A. ELIGIBILITY EVALUATION **VERIFICATION/INFORMATION** **ELIGIBILITY MET**

1. **NON-FINANCIAL CRITERIA:** _____ YES NO
2. **COVERED GROUP:** _____ YES NO
3. **ASSET TRANSFER (IF LONG-TERM CARE)**: _____ YES NO
   DETAILS:
4. **RESOURCES:** TYPE VALUE VERIFICATION

   _____ _____ _____

   _____ _____ _____

   _____ _____ _____

   COUNTABLE RESOURCES $_____ LIMIT:_____ YES NO
5. **INCOME:** SOURCE DATE REC/FREQ. AMOUNT VERIFICATION

   _____ _____ _____ _____

   _____ _____ _____ _____

   _____ _____ _____ _____

   INCOME CALCULATIONS: COUNTABLE INCOME: $_____ LIMIT:_____ YES NO
6. **SPENDDOWN CALCULATION:** SPENDDOWN PERIOD: FROM_____TO_____
7. **INSURANCE CHANGES SINCE LAST ELIGIBILITY DETERMINATION:** _____

B. FINDING: ELIGIBLE INDIVIDUAL(S) & AC:_____ NEXT RENEWAL DUE: _____

INELIGIBLE INDIVIDUALS: _____

REASON: _____MANUAL CITATION: _____

WORKER'S SIGNATURE: _____ DATE: _____

SUPERVISOR'S SIGNATURE: _____ DATE: _____

Attach all verification/documentation to this form.